Advising the Congress on Medicare issues

MIPPA Report: Improving Medicare's Chronic Care Demonstration Programs

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MEDPAC

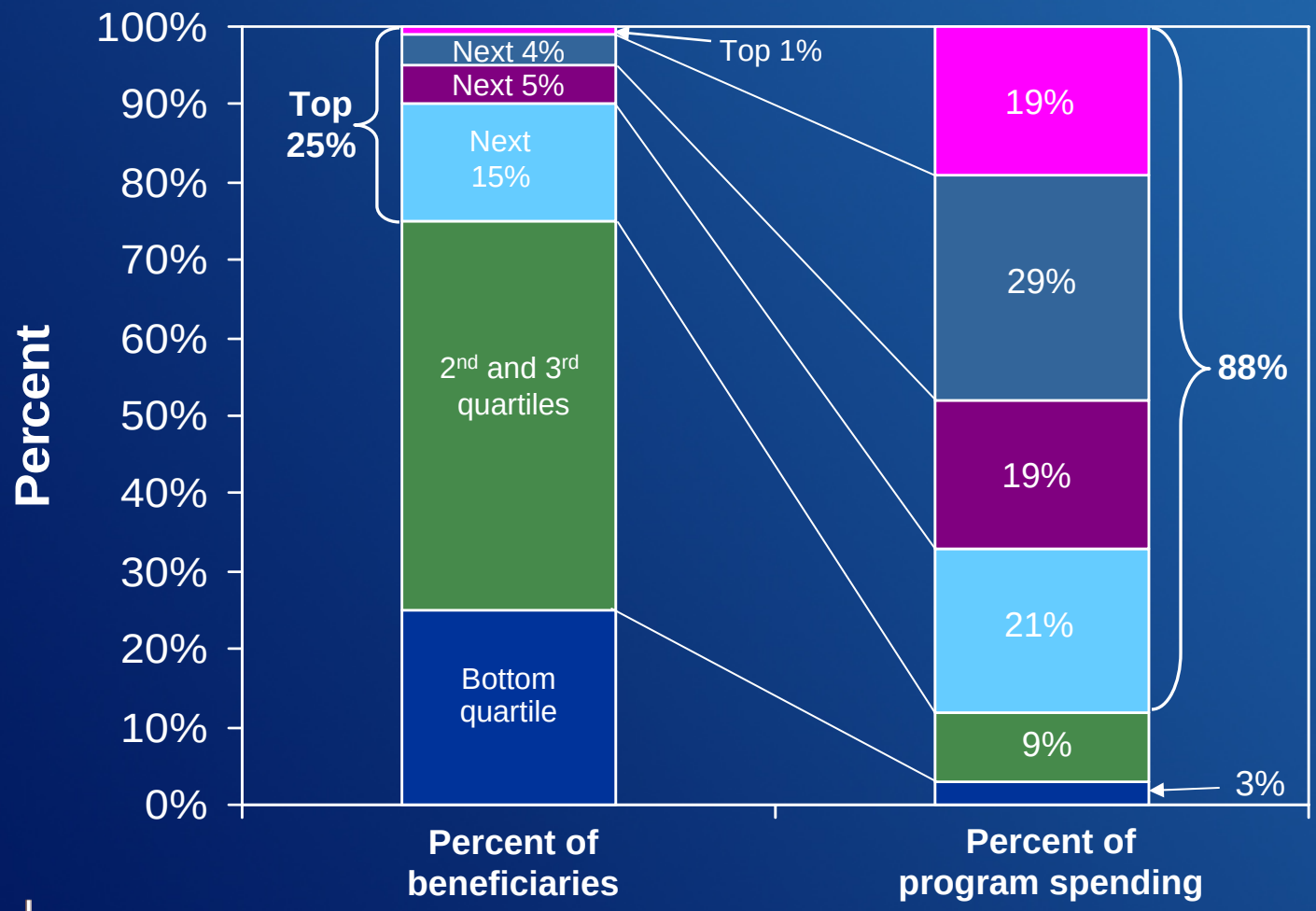
Overview of presentation

- Background on chronic disease and care coordination in fee-for-service Medicare
- MIPPA mandate
- Review care coordination demonstrations/pilot
- Review proposed Medicare Chronic Care Practice Research Network
- Broader issues of Medicare R&D

Chronic disease and care coordination gaps contribute to high costs, low quality

- Spending is concentrated among small percentage of beneficiaries
- 75% of high-cost beneficiaries diagnosed with 1+ chronic conditions (CBO)
- Poor care coordination contributes to high cost, low quality
- Medicare FFS structure and payment policies create disincentives for care coordination

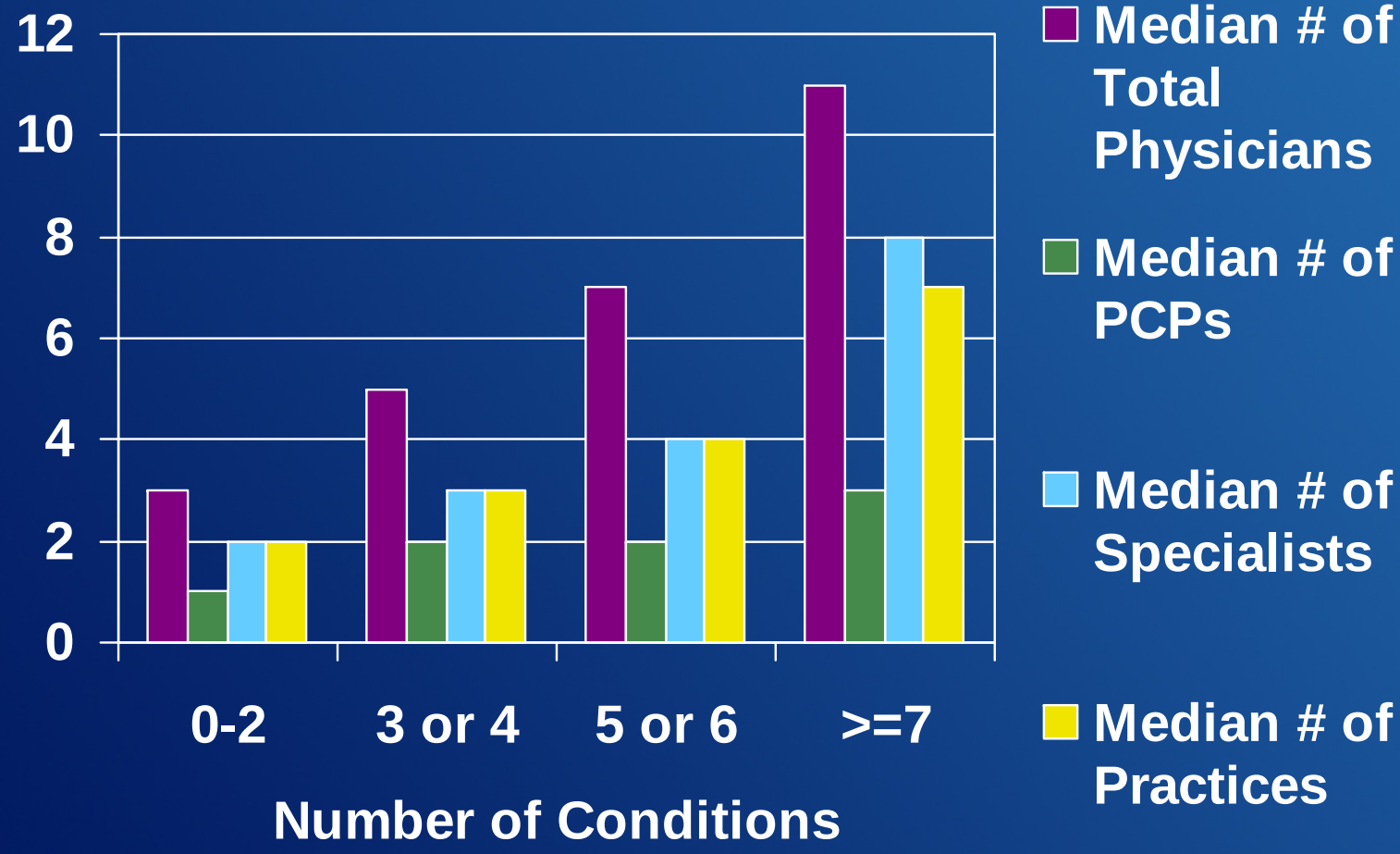
Annual spending is concentrated among small percentage of beneficiaries



MEDPAC

Source: MedPAC June 2004.

Beneficiaries with multiple chronic conditions see more physicians



Source: Pham, et. al. 2007.

MIPPA 2008 mandates Commission study on improving chronic care research

- Assess feasibility and advisability of proposed Medicare Chronic Care Practice Research Network
- Study demonstrations and pilots, specifically including:
  - Medicare Coordinated Care Demonstration
  - Medicare Health Support pilot
- Two other relevant demonstrations also studied:
  - Care Management for High Cost Beneficiaries demonstration
  - Physician Group Practice demonstration
- Report to the Congress by June 15, 2009

Medicare Coordinated Care Demonstration (MCCD)

- Authorized by BBA 1997
  - HHS allowed to implement successful components via regulation if quality and budget neutrality criteria met
- Most sites target beneficiaries with multiple chronic conditions
- Voluntary enrollment, randomization to treatment or control groups
  - 18,400 enrollees by June 2005
  - Treatment group sizes ranged from 92 to 1,511
  - Most sites (9 of 15) had between 400 and 750

MCCD cost and quality results

- None of the programs reduced net Medicare costs
  - Statistically significant ($p<.10$) results ranged from 8.2% to 40.6% higher monthly costs than control group average
- No positive effects on patient adherence measures
- Few positive outcomes on process of care measures
- High levels of beneficiary and provider satisfaction
- Two sites near budget neutral, continuing until 2010
- Final evaluation expected 2010 or 2011

Medicare Health Support pilot (MHS)

- Authorized by MMA 2003
- 8 sites launched in 2005 after competitive RFP process
- Sites paid PMPM fee, at risk for cost and quality
- Research design: “Intent-to-treat” model
- Involved approximately 290,000 beneficiaries with CHF and/or diabetes and HCC >1.35
  - Largest randomized study conducted to date of population-based care management

MHS cost and quality results

- Cumulative fees paid far exceeded savings produced
- Limited impacts on:
  - Beneficiary satisfaction with care
  - Self-management measures
  - Physical and mental health functioning measures
- Positive effects on some process of care measures
  - But no statistically significant effects on hospital admission/readmission rates or ED visits

Care Management for High-Cost Beneficiaries Demonstration

- CMS-initiated demonstration
- Six sites selected through competitive process
  - Required to be physician group, hospital, or IDS
- CMS did not define targeted chronic diseases
  - Each site allowed to propose enrollment eligibility criteria
  - Using risk profiles, not conditions, to identify potential enrollees
  - Most have CHF, diabetes, or chronic kidney disease
- Uses population-based intent-to-treat model
  - Sites paid PMPM fee, at risk for 2.5% cost savings net of fees

Status of Care Management for High-Cost Beneficiaries Demonstration

- Sites started Fall 2005 - Summer 2006
- Current intervention group enrollment about 5,600 beneficiaries in 4 sites
  - Sites range from about 540 to 2,200 enrollees
- CMS recently announced 3 sites extended up to 3 additional years
  - Based on reported cost savings and quality improvements
  - No details of program evaluation released yet

Physician Group Practice (PGP) demonstration

- Authorized by BIPA 2000
- 10 sites selected by competitive application process, began operations in 2005
  - Large (200+ physician) group practices, many also part of integrated delivery system with hospital
  - Primary care providers for about 220,000 beneficiaries
- Pay-for-performance demonstration that creates incentives to improve care coordination

PGP demonstration results to date

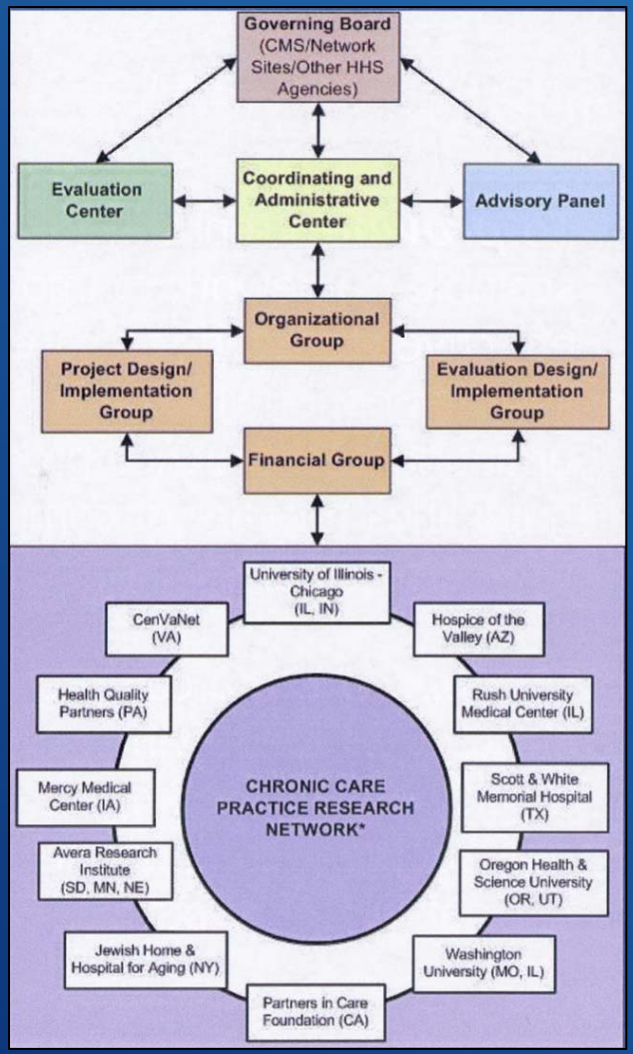
- Costs: Possible reductions in total costs
- Quality: Improvements on quality measures
- CMS extended all programs for 1 additional year (ends March 2009)

Summary of demonstration and pilot results to date

- Costs: Little evidence of cost neutrality or savings
  - Some apparent success with specific program elements and sub-populations
- Quality: Scattered evidence of success improving process, satisfaction, outcomes
- CMS performance: Resource and process constraints
  - Limited flexibility to generate, test, and evaluate potential policy improvements
  - No clear process for translating research into policy

Proposed Medicare Chronic Care Practice Research Network (MCCPRN)

- Coalition of provider and research organizations
  - Academic medical centers, care management service providers, LTC providers
  - 7 organizations also were sites in MCCD
- Practice-based research network (PBRN) model



Key points of MCCPRN proposal

- Proposed functions of network would be to:
  - Test specific care coordination interventions
  - Produce “best practice” guidelines
    - Tool kits, how-to guides, operations manuals
  - Develop faster evaluation methods and measures

- Network would be funded out of Medicare trust funds
  - 2007 legislative proposal included $60 million over 5 years
  - Medicare FFS payment policies would remain in place
  - Fees to network sites would not be at risk for cost outcomes

Concerns about MCCPRN proposal

- Network sites not competitively selected
  - Establishment would set precedent for additional proposals
- Fees would not be at risk for medical costs
- Role of CMS, others outside network in selecting research projects
- Potential duplication of AHRQ PBRNs

Demo/pilot results and MCCPRN proposal raise larger issues about Medicare R&D

- Where should ideas for research and development projects originate?
- How can policy ideas be tested and evaluated more rapidly to create replicable, scalable interventions?
- What changes in Medicare's R&D process will speed up dissemination of evidence-based policies?
- What capabilities should CMS have to execute effective R&D for a $460 billion program?